

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08423

Reg. Dist. No.

8448

CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b REBECCA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle REBECCA	Last ADAMS
4. DATE OF DEATH	Month JULY	Day 8	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1872
9. AGE (In years last birthday) 88 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME BENJAMIN MADDUX		
14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None	17. INFORMANT MARYLAND DENNIS, MARION, MARYLAND	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Disease of heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Chronic but nephritic Chronic myocarditis DUE TO (c) Chronic myocarditis			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General Arterio Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on JULY 8 , 19 60 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARION STATION, Md.			
ACTUAL SIGNATURE <i>George C. Coulbourn</i>	M.D.	DATE SIGNED	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.	MARION STATION, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Manokin Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Manokin, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JUL 15 '60	24b. REGISTRAR'S SIGNATURE <i>George S. Knapp</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08424

8449

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. McCREADY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVELYN		First EVELYN	Middle BROUGHTON
4. DATE OF DEATH JULY 31ST 1960		Month JULY	Day 31ST
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH DEC 23, 1886		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) SHELLTOWN, MD.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EUGENE BROUGHTON	
14. MOTHER'S MAIDEN NAME EVELYN HANEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT LUCILLE MORGAN	Address MARION STATION, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accid. die 7 heart		INTERVAL BETWEEN ONSET AND DEATH 455.2	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis chronic old myocarditis		DUE TO Yeds	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Overexposure of stomach			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 , to JULY 31, 1960 that I last saw the deceased alive on JULY 31ST, 1960 , and that death occurred at 2 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE George Coulbourn M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D. MARION STATION, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 2, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Baptist Cemetery	22d. LOCATION (City, town, or county) (State) Rehobeth--Somerset County-Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8444

CERTIFICATE OF DEATH

Reg. Dist. No.

08425

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Beechwood St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Everett	Middle Joshua	Last Carey
4. DATE OF DEATH	July 20, 1960	Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1896
9. AGE (In years last birthday) 64 yrs.	10. KIND OF BUSINESS OR INDUSTRY Confectionary	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME E. Joshua Carey		14. MOTHER'S MAIDEN NAME Jennie LeCompte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Reba Carey, Princess Anne, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH minutes			
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary arteriosclerosis years			
DUE TO DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-2-60, 19, to 7-20-60, 19, that I last saw the deceased alive on 7-20-60, 19, and that death occurred at 9P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Everett C. Sutter</i>		ADDRESS (Street, city or town, state) Princess Anne, Maryland DATE SIGNED 7-22-60	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60	
22c. NAME OF CEMETERY OR CREMATORIAL Manokin Presbyterian		22d. LOCATION (City, town, or county) Princess Anne, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James L. Hennigan</i>		ADDRESS Princess Anne, Md.	
		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Krause</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8450

CERTIFICATE OF DEATH

08426

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. W. MCCREADY MEMORIAL HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
3. NAME OF DECEASED (Type or print) WILLIAM H COULBOURN		First WILLIAM	Middle H
Last COULBOURN		Last COULBOURN	4. DATE OF DEATH JULY 30TH 1960
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) CRISFIELD, MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISAAC HENRY COULBOURN		14. MOTHER'S MAIDEN NAME JANE E. ROACH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	INFORMANT ISABOL COULBOURN E. MAIN ST CRISFIELD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke of heart disease</i>			
DUE TO 422.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Stroke of my heart</i>			
DUE TO (c) <i>Stroke my heart</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>General arterio sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 , to JULY 30TH 1960 , and that I last saw the deceased alive on JULY 30 , 1960, and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George C. Coulbourn</i>		ADDRESS (Street, city or town, state) MARTON STATION, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Aug. 2, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery	
22d. LOCATION (City, town, or county) Crisfield, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR AUG 4 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>
ADDRESS		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8451

CERTIFICATE OF DEATH

08427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. McCready Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle ESTELLE	Last Cullen
4. DATE OF DEATH	Month July	Day 19	Year 60
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1889
9. AGE (In years at birthday) 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home.	11. BIRTHPLACE (State or foreign country) Crisfield, Md.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Elisha Ward		
14. MOTHER'S MAIDEN NAME Donna Sterling	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None	INFORMANT Son- Reginald Cullen RFD Crisfield, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>490.1</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid Arthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 19th, 1960</u> , to <u>July 19th, 1960</u> , that I last saw the deceased alive on <u>July 19th, 1960</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>33 W Main Crisfield, Md.</u>			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u>	DATE SIGNED <u>7/20/60</u>		
PHYSICIAN'S NAME (Type) Sarah M. Peyton, M.D.	Crisfield, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 22, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 25 '60	24b. REGISTRAR'S SIGNATURE <u>Robert S. Krause</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8452

CERTIFICATE OF DEATH

08428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. McCready Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
3. NAME OF DECEASED (Type or print) Peter		4. DATE OF DEATH July 22nd	
First Middle Last		Month July	Day 22
5. SEX M		6. COLOR OR RACE N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 110?? yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Donald Ward		14. MOTHER'S MAIDEN NAME Leah Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Pauline Schofield Crisfield, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 592X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) Hypertension DUE TO (c) Chronic but reflexive Chronic bronchitis		INTERVAL BETWEEN ONSET AND DEATH 10 day 4 day Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1960, to July 22, 1960, that I last saw the deceased alive on July 22, 1960, and that death occurred at 11:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE George C. Coulbourn		DATE SIGNED	
PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.		Marion Station, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60	
22c. NAME OF CEMETERY OR CREMATORIAL Church Cem		22d. LOCATION (City, town, or county) Hope Well, Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley, Salisbury Ind.		24a. REC'D BY REGISTRAR DATE JUL 29 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF MAIL

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8453

CERTIFICATE OF DEATH

08429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 69	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CARL	Middle LOOMIS	Last EVANS, SR.
4. DATE OF DEATH	Month JULY	Day 9	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker	10b. KIND OF BUSINESS OR INDUSTRY Produce Transport	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JESSE DIGGS EVANS	14. MOTHER'S MAIDEN NAME RACHEL WARD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. N one	INFORMANT BARBARA EVANS, CRISFIELD, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO trama INTERVAL BETWEEN ONSET AND DEATH 1 w/c			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 6 mo. (c) Generalized Arterosclerosis 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 9, 1960 , to July 9, 1960 , that I last saw the deceased alive on July 9, 1960 , and that death occurred at 2:19 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sarah M. Peyton</i>	M.D.	ADDRESS (Street, city or town, state) CRISFIELD, Md.	
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 11, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 15 '60	24b. REGISTRAR'S SIGNATURE Clarence S. Krause

15281

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FOR THE SECRETARY OF STATE. 1928



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08430

8454

CERTIFICATE OF DEATH

Reg. Dist. No.

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Vernon		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Maryland X					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fredrick		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1980		9. AGE (In years last birthday) yrs. 79	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Tonging		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Martin Jones		14. MOTHER'S MAIDEN NAME Ellen Jones							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 723.0		16. SOCIAL SECURITY NO. 214-16-4314		17. INFORMANT Emma Jones, Princess Anne, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 723.0		DUE TO (b) DUE TO (c)		Cerebral Thrombosis Chronic Osteo Arthritis		INTERVAL BETWEEN ONSET AND DEATH 10 days 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Princess Anne, Md		(County)	(State)
21. I certify that I attended the deceased from <u>May 10, 1956</u> to <u>July 23, 1960</u> , that I last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Eldon G. Markman</u> M.D. ADDRESS (Street, city or town, state) <u>Princess Anne, Md</u> DATE SIGNED <u>7/26/60</u>									
PHYSICIAN'S NAME (Type)		Princess Anne, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/60		22c. NAME OF CEMETERY OR CREMATORIAL St. Paul		22d. LOCATION (City, town, or county) MT Vernon, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

CERTIFICATE OF DEATH

MATERIAL

DECEASED PERSON'S NAME

CITY

DECEASED PERSON'S
ADDRESS

DECEASED PERSON'S SOCIAL SECURITY NUMBER

DECEASED PERSON'S
MEDICAL RECORD NUMBERDECEASED PERSON'S
RELATIONSHIP
TO DECEASED PERSONDECEASED PERSON'S
RELATIONSHIP
TO DECEASED PERSONDECEASED PERSON'S
RELATIONSHIP
TO DECEASED PERSONDECEASED PERSON'S
RELATIONSHIP
TO DECEASED PERSON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any detail is necessary, please execute certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Mirian		First Y.	Middle Joynes
4. DATE OF DEATH July 18, 1960	Month July	Day 18	Year 1960
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1960
9. AGE (In years last birthday) 5 yrs.	10. IF UNDER 1YEAR Months 27	11. IF UNDER 24 HRS. Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herschel Joynes		14. MOTHER'S MAIDEN NAME Yvonne Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. - - -	17. INFORMANT Herschel Joynes - Manokin, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 491X Bronchial Pneumonia		2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Nutrol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>R. H. Johnson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		DATE SIGNED July 19, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/19/60	22c. NAME OF CEMETERY OR CREMATORIUM Charles Wesley Cemetery	22d. LOCATION (City, town, or county) Manokin, Maryland (Somerset Co.)
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Johnson</i>	ADDRESS <i>W. L. Johnson</i>	24a. REC'D BY REGISTRAR DATE JUL 20 '60	24b. REGISTRAR'S SIGNATURE <i>Orlina S. Thomas</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8456

CERTIFICATE OF DEATH

Reg. Dist. 08432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 1 HR.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E.W. MCCREADY MEMO HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
3. NAME OF DECEASED (Type or print) SAMUEL R. LEWIS		First SAMUEL	Middle R.
4. DATE OF DEATH JULY 17TH 1960		Last LEWIS	Month Day Year
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT 7, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY Seafood & Farm	11. BIRTHPLACE (State or foreign country) MARION STATION, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL LEWIS	
14. MOTHER'S MAIDEN NAME Emma ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. EDNA LEWIS RFD #1 Box 221A CRISFIELD		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease & Congestive DUE TO 6 weeks (c) Hypertension.			
INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/2 , 19 60 , to JULY 17, 1960 , that I last saw the deceased alive on JULY 17TH 1960 , and that death occurred at 5:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-18-60			
ACTUAL SIGNATURE A. N. Barr, M.D.		M.D.	
PHYSICIAN'S NAME (Type) A. N. Barr, M.D.		22c. NAME OF CEMETERY OR CREMATORIUM CRISFIELD, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1960	
22d. LOCATION (City, town, or county) Crisfield, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.		24a. REC'D BY REGISTRAR DATE JUL 27 '60	
		24b. REGISTRAR'S SIGNATURE C. L. Lewis & Hause	

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1962

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8445

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CERTIFICATE OF DEATH

Reg. Dist. No.

08433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b Life Time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
3. NAME OF DECEASED (Type or print) First Malcha		d. STREET ADDRESS	
4. DATE OF DEATH July 15, 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		9. AGE (In years last birthday) 45 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Manokin Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George D. Maddox		14. MOTHER'S MAIDEN NAME Chorlott Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-5832	
17. INFORMANT Shanley Maddox, Manokin		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1960, to July 14, 1960, that I last saw the deceased alive on July 14, 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Princess Anne, Md. 7-15-60	
ACTUAL SIGNATURE A.C. Lewis, M.D.		DATE SIGNED 7-15-60	
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		22d. LOCATION (City, town, or county) Manokin, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/60	
22c. NAME OF CEMETERY OR CREMATORIAL Samuel Wesley		22d. LOCATION (City, town, or county) Manokin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE JUL 18 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Mead	

CERTIFICATE OF DEATH

MAY 1960

200-10011-01206

100-10011-01206

100-10011-01206

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8457

108434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Somerset		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b C. LENGTH OF STAY IN 1b	
Oriole		Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
at his home		Main Road	
3. NAME OF DECEASED (Type or print)		First	Middle
ALONZA			McDaniel
4. DATE OF DEATH		Month	Day
JULY 15		1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	B. DATE OF BIRTH May 30-1886
8. AGE (In years last birthday) 74 yrs.		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Carpenter		Boat Builder	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
Joseph McDaniel		Elizabeth Shelton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
UNKNOWN		Delmas Shoree-Dames Quarter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarction	
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO	
(b)		Hypertensive cardiovascular disease	
DUE TO		years	
and (c)		Arteriosclerotic heart disease	
years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1960, to July 15, 1960, that I last saw the deceased alive on July 14, 1960, and that death occurred at 2A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Dames Quarter, Md. DATE SIGNED 7-16-60	
PHYSICIAN'S NAME (Type)		Everett C. Sutter, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7-17-60	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
OBIOLE METHODIST		OBIOLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Z. S. Webster		Seaf Island Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 25 '60		Julia S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CEMETELO DE ESTACIÃO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08435

8446

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 71 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Isaac	Middle Thomas	Last Mitchell	4. DATE OF DEATH July 10	Month July	Day 10	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac T. Mitchell				14. MOTHER'S MAIDEN NAME Elva M. Pnnock				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Norman Mitchell Princess Anne, Md.		Address		
yes								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 1 hour								
420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease years								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) asthma, emphysema, malnutrition, avitaminosis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from 7-10-59, 19, to 7-10-60, 19, that I last saw the deceased alive on 7-9-60, 19, and that death occurred at 9A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, Maryland DATE SIGNED 7/12/60								
ACTUAL SIGNATURE Everett C. Sutter		M.D. Physician's NAME (Type) Everett C. Sutter MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-3-1960		22c. NAME OF CEMETERY OR CREMATORIUM St. Andrew Cemetery		22d. LOCATION (City, town, or county) Princess Anne, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Lewis Wilson ADDRESS Princess Anne, Md.								
24a. REC'D BY REGISTRAR DATE JUL 14 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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17

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8447

CERTIFICATE OF DEATH

08436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 46 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		d. STREET ADDRESS Beechwood Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Milbourn Thomas Muir		First	Middle	Last	4. DATE OF DEATH July	Month	Day	Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 4, 1914	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Mercantile		11. BIRTHPLACE (State or foreign country) Princess Anne, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Moody Muir				14. MOTHER'S MAIDEN NAME Dora Taylor					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 2 13-18-4610		17. INFORMANT Mrs. Milbourn Muir, Princess Anne, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH minutes			
420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Hypertensive cardiovascular disease				years			
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		gout				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 9-2-59 , 19 19 , to 7-10-60 , 19 19 , that I last saw the deceased alive on 7-7-60 , 19 19 , and that death occurred at 5A M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>Everett Sutter</i>	M.D.		Princess Anne, Maryland		DATE SIGNED 7/12/60				
PHYSICIAN'S NAME (Type) Everett C. Sutter MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 12, 1960	22c. NAME OF CEMETERY OR CREMATORIAL St. Andrews Cemetery		22d. LOCATION (City, town, or county) Princess Anne, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis Wilson</i>		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE July 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CALIFORNIA STATE DEPARTMENT OF REVENUE - SALVAGE 18

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8458

CERTIFICATE OF DEATH

08437

Reg. Dist. No.

M

X

I

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jeneva	Middle M	Last Powell
4. DATE OF DEATH	Month July	Day 29	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1877
9. AGE (In years last birthday) 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Fairmount, Maryland
13. CITIZEN OF WHAT COUNTRY? U. S. A.	14. MOTHER'S MAIDEN NAME Martha Pearson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. James Bozman	Address Oriole, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
(b) DUE TO Cardiac Decompensation		2 mo.	
(c) DUE TO Hypertensive Cardio-Vascular		3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) IV. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 6, 1960</u> to <u>July 29, 1960</u> , that I last saw the deceased alive on <u>July 29, 1960</u> , and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE B. FRANK GIGANTI M.D.		ADDRESS (Street, city or town, state) 20 Prince William St., Princess Anne, Md. DATE SIGNED 7/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-31-60	22c. NAME OF CEMETERY OR CREMATORIUM Pearson Cemetery	22d. LOCATION (City, town, or county) Fairmount, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Leslie Milam, Ph. Anne Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE AUG 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thrus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8459

CERTIFICATE OF DEATH

08438

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION E.W. MCCREADY MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle LUIA	Last ROSS
4. DATE OF DEATH	Month JULY	Day 16	Year 19 60
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 DEC 22, 1895
9. AGE (In years last birthday) 84 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY Own home	12. BIRTHPLACE (State or foreign country) CRISFIELD, MD.
13. FATHER'S NAME WASHINGTON HICKMAN	14. MOTHER'S MAIDEN NAME HESTER MILES		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Charlie Ross, 1105 W. Hamburg, Baltimore, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430 <i>Devascularization Heart Disease</i> INTERVAL BETWEEN ONSET AND DEATH 1 mo DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Concurrent of Cerebral - operation in 20 yrs. ago			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) CRISFIELD (County) WICHTON (State) MARYLAND
21. I certify that I attended the deceased from JULY 16, 1960 to JULY 16, 1960 that I last saw the deceased alive on JULY 16, 1960 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton	ADDRESS (Street, city or town, state) 3342 Route One, Crisfield, Md. DATE SIGNED 7/17/60		
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1960	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md. (State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8460

CERTIFICATE OF DEATH

08439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Princess Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Addie		Middle Mae	Last Simpkins
4. DATE OF DEATH July 10		Month	Day
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 24, 1888		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during usual work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Georgia		11. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Cooke		14. MOTHER'S MAIDEN NAME Mary Everingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Fred Simpkins Sr. RDF. Princess Anne Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-6-57</u> , 19, to <u>7-10-60</u> , 19, that I last saw the deceased alive on <u>7-6-60</u> , 19, and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Princess Anne, Maryland	
ACTUAL SIGNATURE <u>Everett Sutter</u>		DATE SIGNED 7/12/60	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 7/12/60		22c. NAME OF CEMETERY OR CREMATORIAL Asbury	
22d. LOCATION (City, town, or county) Mt. Vernon, Md.		23. FUNERAL DIRECTOR'S SIGNATURE James Sherman	
24a. REC'D BY REGISTRAR DATE JUL 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Fink	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8461

CERTIFICATE OF DEATH

Reg. Dist. No.

08440

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rumbley		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First May	Middle Sterling	Last Smith	4. DATE OF DEATH Month July	Day 22	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1883	9. AGE (In years lost birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Hopewell, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Susan Dorsey		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Calvert O. Meredith, Rumbley, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		INTERVAL BETWEEN ONSET AND DEATH class			
420.0		(b) Arteriosclerotic Heart Disease		(c)		Died 15 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County)	(State)
21. I certify that I attended the deceased from 7/13 , 19 60 , to 7/22 , 19 60 , that I last saw the deceased alive on 7/22 , 19 60 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.				DATE SIGNED			
ACTUAL SIGNATURE A. N. Barr, M.D.	M.D.		Gulfport, Md.		7/23/60		
PHYSICIAN'S NAME (Type) A. N. Barr, M.D.			CRISFIELD MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 25, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Mariners Cemetery	22d. LOCATION (City, town, or county) Grisfield			(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson, Princess Anne, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8443

CERTIFICATE OF DEATH

Reg. Dist. No. 18443

1. PLACE OF DEATH a. COUNTY <i>SOMERSET</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CRISEFIELD</i>		c. LENGTH OF STAY IN 1b <i>LIFETIME</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>AT HIS HOME</i>		e. STREET ADDRESS <i>#9- SECOND ST.</i>	
3. NAME OF DECEASED (Type or print) <i>CHARLES W. STERLING</i>		4. DATE OF DEATH <i>JULY 11 1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>JUNE 26 - 1891</i>	9. AGE (In years lost/birthday) yrs. <i>69</i>
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Water man</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>ROBERT J. STERLING</i>		14. MOTHER'S MAIDEN NAME <i>ANNIE MOSHER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>BERTIE LEA STERLING Cressfield</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) DUE TO (c)		Coronary Thrombosis Intervall between onset and death <i>25 min</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Paraplegia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1947, to _____, 1960, that I last saw the deceased alive on _____, and that death occurred at _____, M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Cressfield, Md.</i>	
ACTUAL SIGNATURE <i>C. G. Ranley</i>	DATE SIGNED <i>7-12-60</i>		
PHYSICIAN'S NAME (Type) <i>C. G. Ranley</i>	M.D.		
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-12-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury</i>	22d. LOCATION (City, town, or county) <i>Cressfield Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Webster Cressfield Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>JUL 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Times</i>

STATE OF HAWAII - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8462

CERTIFICATE OF DEATH

Reg. Dist. No.

48442

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Somerset — MARYLAND		a. STATE MARYLAND b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Dame's Quarter 10 days CHANCE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS At Home of Sister Main Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
LILLIAN		Mae	WEBSTER
4. DATE OF DEATH		Month	Day
JULY 5		Year	1960
5. SEX		6. COLOR OR RACE	
FEMALE		WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
59 yrs.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Seamstress		Shirt Factory	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME	
Calvin Bozman		May White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		213-16-7553	
17. INFORMANT		Address	
Rupert Webster		CHANCE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18 days	
33X		Cerebral Thrombosis	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)	
DUE TO			
(c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17, 1960 to July 5, 1960, that I last saw the deceased alive on July 5, 1960, and that death occurred at 4:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Princess Anne, MD. DATE SIGNED 7-6-60	
ACTUAL SIGNATURE		Euron G. M. Montessori	
PHYSICIAN'S NAME (Type)		Princess Anne, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7-8-60	
22c. NAME OF CEMETERY OR Crematory		22d. LOCATION (City, town, or county)	
Rock Creek		CHANCE	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
R. J. Webster Seal Disraeli		JUL 13 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
J. S. Kraus			
VS A15 (4) 15M 9/55		DATE	

